DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Huachuca, Arizona 85613-7079

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No. 40-37

Medical Services

CONTROL AND USE OF OUTPATIENT MEDICAL RECORDS

1. HISTORY: This issue publishes a revision of this publication.

2. PURPOSE: This pamphlet is designed to train new and regular employees of the Medical Department Activity (MEDDAC) in the proper handling of Outpatient and Health Records.

3. SCOPE. This program applies to all health care personnel within the MEDDAC, Fort Huachuca and to those administrative personnel who have an official need to handle medical records. The medical and administrative staff that handles patient medical records should review the contents of this pamphlet as soon as practical after being assigned to their duties. This orientation should take place no later than 90 days after reporting for duty and should be reviewed periodically as deemed necessary by the chief nurse/physician of the medical care unit.

4. REFERENCE. AR 40-66, Medical Record Administration

5 RESPONSIBILITIES.

5.1 The commander of Raymond W. Bliss Army Health Center (RWBAHC) is the official custodian of the medical records located at this facility, Behavioral Health, Preventive Medicine Wellness and Readiness Service, Alcohol and Substance Abuse Program (ASAP), Department of Military Medicine (DMM), and Occupational Health.

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*This publication supersedes MEDDAC PAM 40-37, 29 Mar 04.

5.1.1 RWBAHC maintains all Outpatient Treatment Records (OTRs) for Retirees and their Dependents and Dependent records of MEDDAC, DENTAC, Vet Activity personnel and Marine Corps Detachment. All medical records of Coast Guard and Foreign Military are kept in the Outpatient Medical Records section in Patient Administration Division (PAD)

5.1.2 Department of Military Medicine maintains all military HRs, except Military Intelligence (MI) Units, which will be maintained at MI Student Clinic.

5.2 The Chief, Patient Administration Division (C,PAD) will act for the commander in matters of handling medical records. The C, PAD is charged to ensure that all components of control and use of OTRs are properly administered throughout MEDDAC.

5.3 The Supervisor, Medical Records Branch is the MEDDAC subject matter expert on the control and use of OTRs and HRs. He/She is responsible for educating the entire MEDDAC staff by conducting staff assistance visits at all MEDDAC locations maintaining medical records.

5.4 Health care providers will record promptly and correctly all patient observations, treatments and care.

5.5 Administrative personnel of all MEDDAC activities that use medical information must protect the privacy and confidentiality of that information.

6. RECORD OWNERSHIP. Army medical records are the property of the United States Government.

7. CONFIDENTIALITY OF MEDICAL INFORMATION.

7.1 It is the responsibility of all persons working within the MEDDAC to protect the confidentiality of medical information. Unauthorized disclosure of medical information is grounds for administrative or disciplinary action against the informant.

7.2 Personnel not involved in a patient's care will not have access to a patient's record. When medical information is requested, all such requests will be referred to the Patient Administration Division (PAD).

7.3 Medical record areas are restricted in accordance with (IAW) AR 40-66. Personnel not listed on the Access Roster or not cleared by the C, PAD will not be permitted in the records area. After normal duty hours access to medical records may be obtained through the Patient Accountability Branch.

8. REQUEST FOR MEDICAL INFORMATION.

8.1 Should a patient request the release of specific elements of medical information from a physician to a third party, they must complete the front side of a DA Form 5006-R (Authorization for Disclosure of Information) and then sign the form authorizing the release.

8.2 Specifics on release of medical information can be found in AR 40-66.

8.3 The following is a list of medical records that are maintained separate from the primary medical record:

8.3.1 Behavioral Health Records.

8.3.2 Occupational Health Records.

8.3.3 Ambulatory Surgery Records.

8.3.4 Allergy Records.

8.3.5 ASAP Records.

8.3.6 Physical Therapy Records.

9. PATIENT IDENTIFICATION. The patient's identification section will be completed when each record document is initiated. The Patient's Recording Card (PRC) if available, should be used for the HR and OTR. When mechanical imprinting is not available, patient identification will be typed or printed in black ink. Patient identification must include at least the patient's name, rank, grade or status: his/her family member prefix (FMP) and sponsor's social security number (SSN). The patient's recording card is designed only to make printing of identification data on a record complete and legible and for the charge out of the medical record; it will not be used to determine eligibility for care. PRCs from other facilities will not be used unless the patient is only here on leave or in a TDY status. PRCs contain a Military Treatment Facility (MTF) code, which could delay the filing of documents in the patient's record.

10. ELECTRONIC CONTROL OF MEDICAL RECORDS/CHARGE OUT.

10.1 The current physical location or destination of each medical record must be known at all times. In order to accomplish this, all clerks have been assigned a secondary menu for Medical Records Tracking (MRT) in the Composite Health Care System (CHCS) to document the movement of each record charged to the clinics. This menu allows each clerk to "Charge" a record into the clinic from the patient of "Re-Charge" a record from one provider to another provider.

10.2 For outlying clinics, records removed from the shelf for internal usage MUST be accounted for either in CHCS or a logbook that is reconciled at the end of the duty day.

10.3 Records will not be "Charged" to patients without an exception by the Chief of PAD. RWBAHC maintains a closed record system. Patients requiring medical records for network appointments will be directed to the correspondence section of PAD to request a copy of their record.

10.4 At no time should a medical record be released to the patient by a provider. The provider will return the medical record to the desk clerk.

10.5 Medical Records being held at Outpatient Medical Records for return to DMM or MI Student Clinic will be Re-Charged to "Code 564 Holding 1 for DMM" and "Code 565 Holding 2 for MI Student Clinic".

10.6 Medical records being transported by the courier from Outpatient Records Room will be Re-Charged by the courier to "TRANSPORT-1 or TRANSPORT-2". When the records are received at the designated record room, these records will be "Checked In" immediately.

10.7 When a patient is known to have possession of their medical record, record rooms will notify patients by Post Cards in an attempt to retrieve the Medical Records.

10.8 Records will be charged out no longer than necessary. Records sent to in-house clinics at RWBAHC will be returned the same day as the clinic visit. The 72 hour purge of all charge-outs will be conducted on a daily basis.

10.9 The clinic in original receipt of a medical record is responsible for the record until it is returned to the records Home Location.

11. PREPARATION AND USE OF THE OUTPATIENT TREATMENT RECORD.

11.1 PAD is responsible for the initial preparation and review of the OTR and HRs.

11.2 Clinics are responsible for ensuring that any additional information and/or forms added to the OTR or HR is completed/added in accordance with AR 40-66.

11.3 Use of the SF 600 (Chronological Record of Medical Care):

11.3.1 The identification data at the bottom of the form will be completed IAW paragraph 9 below.. The "Records Maintained at" block must be completed to show where the patient's medical records are maintained. This will assist the OPR staff and its affiliates in forwarding documents to the appropriate MTF.

11.3.2 Each entry on the SF 600 must show the date and time of the visit and the Medical Treatment Facility (MTF) involved. Each entry must be signed by the person making the entry. The use of "Rubber Stamped Signatures" is unauthorized.

11.4 AHLTA entries are valid **"**documents" in the OPR and must be completed and signed electronically at time of care. Hard copies will not be printed for inclusion in the OPR.

12. STAFF ASSISTANCE VISITS AND REQUEST FOR ASSISTANCE: Staff Assistance Visits will be conducted as follows:

12.1 The Supervisor, Medical Records Branch (MRB) or her/his representative will conduct the following regularly scheduled visits to the following locations:

12.1.1 DMM and MI Student Clinic monthly.

12.1.2 ASAP - upon request.

12.1.3 Mental Health - upon request

12.2 All other areas of MEDDAC are encouraged to contact the Supervisor, MRB or her/his representative for assistance.

13. SUPPORT FOR THE MEDDAC PERFORMANCE IMPROVEMENT:

13.1 Medical records review will be conducted both formally and informally, every time a medical record is handled. Discrepancies will be corrected on the spot whenever possible. When a discrepancy is noted, it will be corrected by the Provider. The medical record will be charged out to the Provider for appropriate action. All medical clerks will routinely conduct the administrative review of each medical record handled. Twenty records per month will be reviewed and the results sent to the Medical Record Review Committee and then forwarded to the Executive Committee of the Professional Staff.

13.2 Medical records that have various alert flags:

13.2.1 Update the Master Problems List - Providers, Nurses and Medical Corp persons will review the patient's record for "Allergies/Sensitivities", "Medications", invasive procedures and other major/minor problems and annotate the Master Problem List.

13.2.2 DA Form 3365 - Providers are required to acknowledge a patient's notification of allergies and or sensitivities by signing the form.

13.2.3 Sign the Privacy Act and the Notice of Privacy Practices (NOPP) stickers labeled on the back of the medical record - Medical Clerks, Nurses, Medical Corp Personnel and Providers will ensure that the patient signs the DA Form 2005 located at part four of a "Four Part Record Jacket" and part two in a "Two Part Record Jacket".

13.2.4. Review each record for appropriate “Third Party Insurance” or “No Third Party Insurance” sticker. Staff will inquire about changes to insurance status with each episode of care.

The proponent of this publication is the Patient Administration Division. Users are invited to send comments and suggested improvements on DA Form 2028 directly to PAD, ATTN: MCXJ-PA, USA MEDDAC, Ft. Huachuca, AZ 85613-7079

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